

# ARCHIVES OF PEDIATRICS

A MONTHLY DEVOTED TO THE  
DISEASES OF INFANTS AND CHILDREN

JOHN FITCH LANDON, M.D., Editor

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### REFERENCES

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- (4) Joslin, C. L., and Bradley, J. E., *Journal of Pediatrics*, Vol. 39, No. 3, pp. 325-329 (1951).

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Wallace R. Roy, Ph.D., Director of Research



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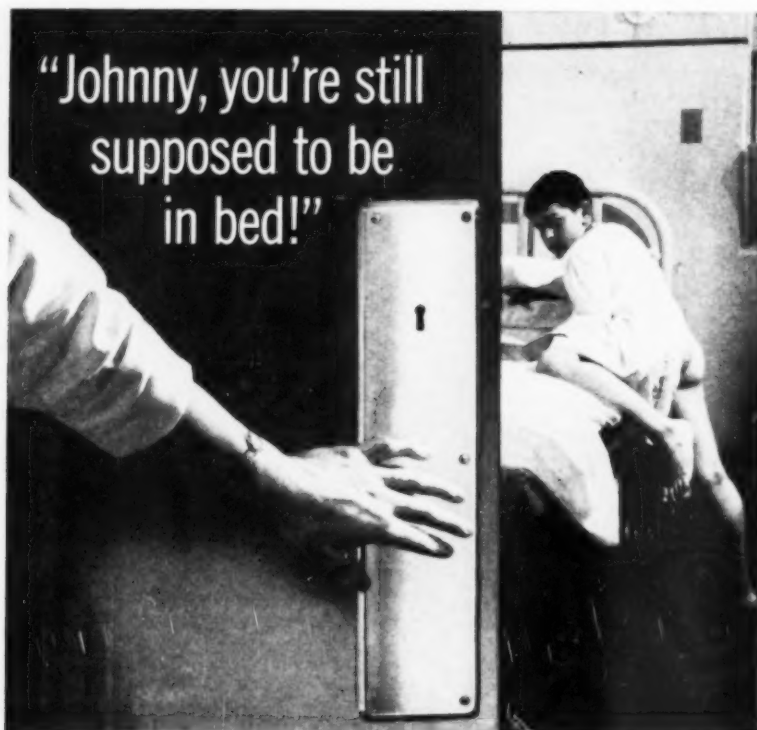
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\*Journal of Pediatrics 39: 325 1951

\*\*Bull, Johns Hopkins Hosp. 87: 569 1950

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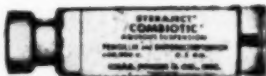
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VOL. 69

DECEMBER 1952

No. 12

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## ENDOCARDIAL SCLEROSIS

### REPORT OF CASE

MILTON H. HOLLANDER, LT. COLONEL, MEDICAL CORPS, U.S.A.\*

BEDFORD H. BERREY, CAPTAIN, MEDICAL CORPS, A.U.S.\*\*

AND

PAUL W. PALMER, CAPTAIN, MEDICAL CORPS, U.S.A.\*\*\*

Denver, Colo.

Endocardial sclerosis is a congenital defect of the heart of unknown etiology associated with cardiac enlargement and resulting in sudden death during infancy. The subject has long been a controversial one, variously termed fetal endocarditis<sup>1</sup>, fetal endomyocarditis<sup>2</sup> and endocardial fibroelastosis<sup>3</sup>. It is not discussed in Taussig's book on "Congenital Malformations of the Heart."

For many years this type of congenital heart abnormality was separated from the general group of congenital heart malformations because of the persistent belief that it had its origin in an inflammatory process. Early investigators felt that an inflammatory process involving the heart, occurring during the period of gestation following the formation of the major organ systems, was at fault<sup>4</sup>. However, the occurrence of fetal endocarditis has never been conclusively established<sup>5</sup>.

Recent investigators favor a developmental origin for endocardial sclerosis. In 1941, Wearn<sup>6</sup> demonstrated, in clear anatomic detail, the components of the coronary circuit nourishing the muscle walls of the heart. The arteriosinusoidal, arterioluminal and thebe-

From the Pediatric and Pathology Services, Fitzsimons Army Hospital, Denver, Colo.  
\*Senior Resident, Pediatrics (now stationed at U. S. Army Hospital, Fort Hamilton, Brooklyn, New York); \*\*Chief, Pediatrics; \*\*\*Resident, Pathology.



sian vessels branch off directly from the coronary arterioles to traverse the auricular and ventricular walls and empty into the chambers. In the same year, Gross<sup>5</sup> notes that the "myocardial lesions usually seen in so-called fetal endocarditis closely resemble healed bland infarcts." He suggested that such infarction might result from obliteration of the arterioluminal, arteriosinusoidal and thebesian vessels by fibrosis of the endocardium. He was unable to find evidence of inflammatory residua.

In 1946, Cosgrove and Kaump<sup>7</sup> again observed the resemblance of the myocardial lesions to infarcts, stressing the parallelism between the extent of myocardial and endocardial involvement. They noted the variability of gross pathologic changes, including thickening and opacity of the endocardium in the simpler forms, with distortion of the valves in the more severe cases.

The present concept of the pathogenesis of endocardial sclerosis is as follows<sup>3, 5, 8, 9</sup>: For some unknown reason, probably developmental, there occurs moderate to marked hyperplasia of the elastic tissue in the thickened endocardium. This thickened fibroelastic layer interferes with the emptying of the arterioluminal vessel into the atrial and ventricular chambers because of constriction of their orifices. With the establishment of obstruction to the flow of blood, dilatation of the intramyocardial capillaries develops, accompanied by partial stasis. Myocardial anoxia is reflected in dilatation, hypertrophy and ultimate failure of the ventricle.

This concept explains the myocardial degeneration and fibrosis. The heart muscle undergoes fatty infiltration, accompanied by muscle atrophy and degeneration, and finally fibrous infiltration and replacement.

#### CLINICAL FINDINGS

Infants with this condition generally follow a rather typical clinical course. They are usually normal at birth. The onset of signs or symptoms is sudden. Within a few months, the infants become irritable and develop feeding problems with refusal of part of their feedings or frequent vomiting, and consequently fail to gain weight normally. As the heart progressively enlarges, coughing and other symptoms of apparent respiratory infection become prominent. Attacks of dyspnea, with or without cyanosis, occur, after which the patient may temporarily improve only to relapse later. The patient may die during one of these attacks.

Roentgenograms of the chest reveal a greatly enlarged, globular heart with no specific contour, with normal lung vascularity. The total size of the heart may be so great that it extends forward causing prominence of the left anterior chest wall. Soft to loud, systolic murmurs, of a non-diagnostic quality may be heard over any part of the precordium. In a significant number of cases there may be no murmurs. The liver is usually enlarged though not remarkably; the spleen is occasionally palpable.

Electrocardiograms do not show any characteristic abnormalities.

#### PATHOLOGIC FEATURES

The heart is grossly enlarged and usually weighs  $2\frac{1}{2}$  to 4 times the normal. There is biventricular hypertrophy, predominantly left ventricular as a rule. The mural endocardium is markedly thickened, usually best developed over the anteroseptal surface of the left ventricle. This thickening occasionally occurs throughout the left ventricle and auricle, and is rarely best developed in the right ventricle. The papillary muscles are often incompletely separated from the ventricular wall, and chordae tendineae may enter the myocardium directly instead of being attached to the tip of a papillary muscle. Associated deformity of the mitral or aortic valves, characterized by thickening of the cusps with rolling of the free margin, has been found in the majority of cases.

Microscopic examination reveals replacement of the endocardium with a thick layer of collagenous tissue. In some cases, there is a great increase in elastic fibers. The underlying myocardial fibers are swollen and vacuolated and may show loss of nuclei and cross-striations. Tissue examination has failed to disclose Aschoff bodies of rheumatic carditis, "Bracht-Waechter" bodies of bacterial carditis, or the myocardial inclusions of toxoplasmosis. The effected valves are simply thickened but not otherwise abnormal microscopically.

#### DIFFERENTIAL DIAGNOSIS

At the present time it is not possible to make a definitive diagnosis of endocardial sclerosis during the lifetime of the patient. The disease may be confused with glycogen storage disease of the heart, which generally produces an identical clinical picture<sup>10</sup>. Other conditions to be considered include: anomalous origin of the left coronary artery from the pulmonary artery, rhabdomyoma, beri-

beri, Fiedler's acute isolated myocarditis, and idiopathic hypertrophy of the cardiac muscle.

#### PROGNOSIS

The prognosis is poor. After the clinical picture develops, the duration of life is rather short, often not more than ten days. Death,

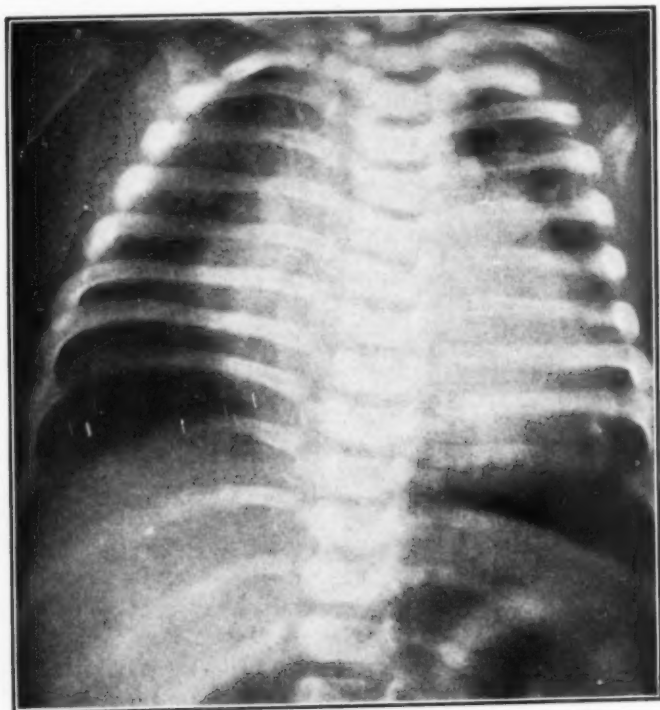


Fig. 1. Roentgenogram of patient at age three months.

as a rule, comes on prior to two years of age, the average being 4 to 6 months, and is frequently a sudden affair with cardiac failure the terminal event.

#### TREATMENT

Treatment is symptomatic. Digitalis offers temporary relief for cardiac failure, and oxygen will lessen the cyanosis, dyspnea and restlessness.

## CASE REPORT

A 3-months-old white female was admitted to the Pediatrics Section, Fitzsimons Army Hospital, July 12, 1951, with chief complaints of dyspnea, feeding difficulties and failure to gain weight, all of two weeks' duration. She was the product of a full term, normal pregnancy, delivered by cesarean section because of cephalopelvic disproportion. Birth weight was eight pounds four ounces, and she was discharged home at seven days of age. She progressed normally until the onset of her present illness.

At 2½ months of age, for no apparent reason, she became irritable when fed and refused part of her feedings. The formula was changed without noticeable improvement. A few days later mild dyspnea and cyanosis developed. Physical examination revealed a markedly enlarged heart, with almost complete absence of breath sounds over the left chest. No cardiac murmurs were heard. The respiratory rate was 60 to 80 per minute. The liver was palpable four cm. below the right costal margin. A roentgenogram (Fig. 1) revealed a large, globular shaped heart almost completely filling the left chest and a portion of the right. Oxygen and digitalis were used with some clinical improvement, and the child was transferred to Fitzsimons Army Hospital.

## COURSE IN HOSPITAL

On admission to this hospital, physical examination showed the child to be comfortable in oxygen and not cyanotic. She had a weak cry which persisted throughout her hospitalization. Obvious left anterior chest enlargement was present. There was tachycardia of 120 to 150 per minute, and a respiratory rate of 55 to 70 per minute. The heart was enlarged on percussion both to the left and right. There were no thrills, shocks or murmurs.

Digitalis was discontinued upon hospitalization and it was not necessary to re-digitalize her. She could be kept out of oxygen for 2 to 3 hours at a time; however, during these intervals she would become progressively more hyperpneic, up to about 100 respirations a minute. Return to higher oxygen concentrations produced a decrease to about 50 a minute. Occasionally a few fine râles were heard in the left base, felt to be secondary to compression of the overlying lung. Because of this finding and the very weak cry, an

associated vascular ring was considered but ruled out with a normal esophogram and tracheogram.

Following admission, a small left posterolateral mass became palpable and was thought to be the tip of the spleen. Since this might possibly have represented an enlarged kidney, a subcutane-

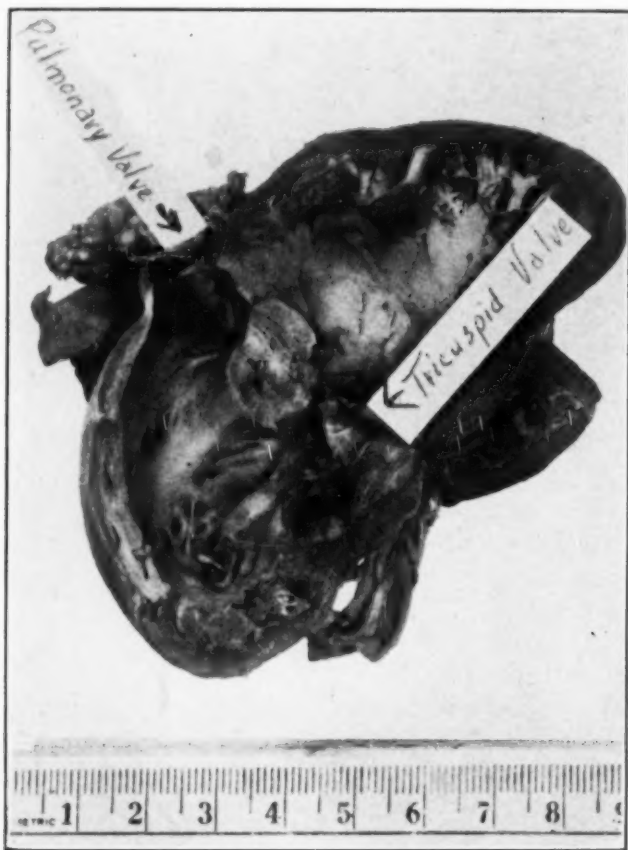


Fig. 2. Heart showing right ventricle with grayish-white, opaque endocardium and thickened ventricular wall.

ous pyelogram was done and interpreted as normal. Serial chest roentgenograms revealed no change in the size or contour of the heart. Complete blood counts and repeated urinalyses were normal. Serial electrocardiograms were non-contributory. A blood culture



remained sterile. The NPN was 40 and 43 on two occasions. Fasting blood sugar was 78 mg. per cent and the adrenalin tolerance test yielded a normal curve.

She was a relatively poor eater and failed to gain weight during her stay in the hospital. A few weeks after admission, a grade I systolic murmur could be heard over the lower precordium. This finding was inconstant, present some days and absent others. The general course was progressively downhill and she expired suddenly three months after admission at the age of 6½ months. An autopsy was performed.

#### POSTMORTEM EXAMINATION

*Gross:* Except for slight congestive hepatomegaly and splenomegaly, the only findings were in the heart (Fig. 2). The heart weighed 92 grams (normal, 31 grams). The epicardium was smooth, glistening and transparent. The myocardium was uniform reddish-brown with no focal softening or fibrosis. The left ventricular wall averaged 1.0 cm. in thickness and the right ventricular wall 0.8 cm. The endocardium was smooth, glistening, thickened, grayish-white and opaque. The thickening and opacity were decidedly more marked in the right ventricle, and the papillary muscles in the right ventricle were incompletely formed and blended with the ventricular wall. The chordae tendineae of the tricuspid valve were diffusely thickened and several entered the myocardium directly, showing no attachment to the tip of a papillary muscle.

Valves were normally formed and valve cusps were thin and delicate. The circumferential measurements of valve rings were: aortic, 2.4 cm.; pulmonic, 3.3 cm.; mitral, 4.4 cm.; tricuspid, 5.4 cm. The foramen ovale was anatomically patent, measuring 1.8 cm. in diameter. It appeared to be functionally closed. The coronary arteries showed no anomalies, arising from the aorta and branching in a normal manner. The ductus arteriosus was closed and major arterial trunks were normal.

*Microscopic:* Microscopic sections showed the endocardium to be replaced with a thick layer of fairly acellular collagenous tissue. Elastic stains demonstrated large numbers of elastic fibers arranged throughout the entire depth of the thickened endocardium (Fig. 3). The underlying myocardial fibers showed swelling and vacuolization of their cytoplasm. Many fibers revealed loss of striations and

nuclei. The epicardium and coronary arteries were not unusual. No inflammatory cells and no Aschoff or Bracht-Waechter bodies were present.

#### DISCUSSION

The duration of life following the onset of symptoms in endocardial sclerosis is generally short, about two weeks or less. Review

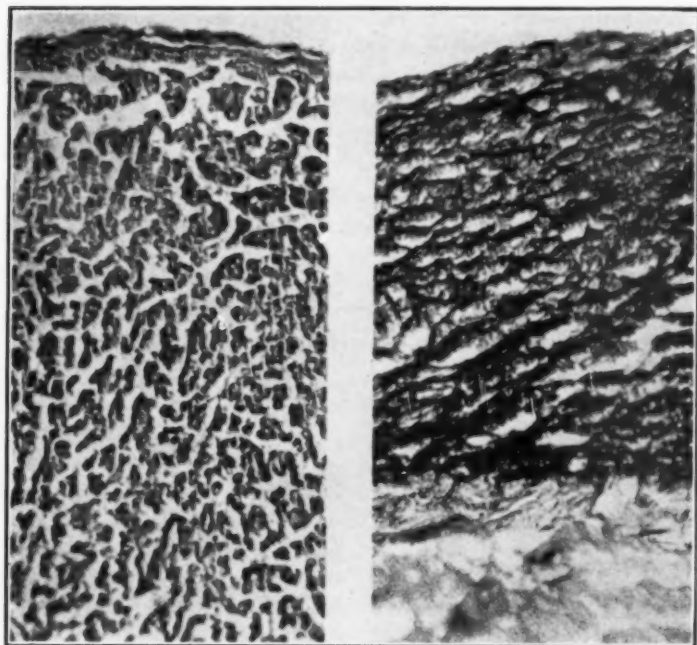


Fig. 3. Elastic tissue stain. *Left:* Normal heart in infant age six months, showing thin layer of endocardium at top of picture and normal myocardium below. *Right:* Case described showing markedly thickened endocardium with increased number of elastic fibers and hypertrophied, vacuolated myocardial fibers below. Both x 300.

of the literature<sup>5, 9, 11, 12</sup> reveals that cases with rapid demise consistently show a mural lesion involving the left ventricle. Our case showed greater involvement of the right ventricle than the left. It is quite probable that the longer duration of life with symptoms (4 months) can be explained on the basis of preponderant right ventricular pathology. This is consistent with the poorer prognosis

in cases of anomalous origin of the left coronary artery from the pulmonary artery as compared with the good prognosis when the right coronary artery arises from the pulmonary artery. These observations would indicate that venous blood appears to be adequate for the nutrition of the right ventricle but not for that of the left.

## SUMMARY

A diagnosis of endocardial sclerosis was entertained in this case on admission to the hospital based on the history, physical examination (cardiomegaly without cardiac murmur, hyperpnea and hepatomegaly), roentgenogram (enlarged, globular shaped heart) and normal electrocardiograms. Due to the present state of our knowledge, it is not possible to positively establish the diagnosis ante mortem.

In a previously apparently healthy baby, the sudden onset of feeding difficulty, cyanosis and dyspnea, with or without cardiac murmurs, should suggest the possibility of endocardial sclerosis.

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## TREATMENT OF DIAPER RASH\*

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Diaper rash, both mild and severe, is a persistent problem which vexes many mothers. Traditionally, the treatment suggested is in cream or ointment form, and while these methods are useful and frequently satisfactory, there are several practical objections to them. Chief among these is the soiling and staining of clothing and bed linen, which is sometimes permanent. Also, the skin is frequently left sticky, and on subsequent urination and bowel movements a pasty, thick residue is left which requires firm and vigorous rubbing to remove. This results in trauma to the skin over the affected areas, which perpetuates and aggravates the condition.

If a satisfactory solution or liquid could be utilized in this very common skin irritation of children, many of these objections would be eliminated. Some attempts in this direction are being made, and one of the materials suggested is Bactine.<sup>†</sup> This preparation has been tested, and is in popular and safe use as a general germicide and antiseptic, as well as a fungicide and disinfectant.

The present study has been conducted in order to determine the usefulness of Bactine (used in full strength) as a treatment for diaper irritation and excoriation, and its possible usefulness in other minor skin conditions occurring in infants. We have also attempted to get some impression from the nurses and others using the material as to its acceptability on their part over a long period—effect on skin of hands, clothing, bed clothes, etc.

Material for the study was drawn from the New York Foundling Hospital, which has in residence about 250 infants and children under two years of age. The Foundling Hospital is a fruitful field, since most of the infants are abandoned or neglected, and on admission diaper excoriations often are quite severe.

The cases of diaper rash have been separated into two designa-

\*From the Department of Pediatrics, New York Foundling Hospital.

<sup>†</sup>"Bactine" is the registered trademark of Miles Laboratories, Inc., for a clear, colorless liquid, faintly aromatic, containing di-isobutyl cresoxy ethoxy ethyl dimethyl benzyl ammonium chloride, polyethylene glycol, mono-iso-octyl phenyl ether, propylene glycol, chlorothymol, alcohol 4%, camphor, methyl, essential oils, and water q.s.

tions—mild and severe. Mild rashes are those in which only erythema or irritation of the buttocks was present. Severe cases are those in which thighs, abdomen and genitalia were affected, and all cases involving broken skin, pustules or excoriation.

Of the 272 cases, 138 were test cases treated with Bactine, and 134 were used as controls and were treated with a variety of other preparations (in ointment form) specifically intended for use in the handling of diaper rash and excoriation. Of this number, 255 were cases of diaper rash, and 17 suffered from other skin disorders. The babies suffering from conditions other than diaper rash were treated exclusively with Bactine.

	RESULTS		
<i>Bactine</i>	Good	Fair	Poor
Diaper rash—severe .....	37	13	10
Diaper rash—mild .....	32	19	10
	<hr/> 69	<hr/> 32	<hr/> 20
<i>Controls</i>			
Diaper rash—severe .....	34	19	10
Diaper rash—mild .....	44	17	10
	<hr/> 78	<hr/> 36	<hr/> 20

A classification of "good" constitutes improvement with complete clearing within seven days in all but severe cases in which excoriation was present. For these, "good" indicates improvement with complete recovery within ten days. A classification of "fair" constitutes improving with complete clearing within 14 days, while "poor" indicates no result within 14 days.

The difference in results with Bactine against other preparations is obviously not significant in cases of diaper rash. However, Bactine was as effective as any other standard preparation used, and had several additional advantages. It was convenient and pleasant to use, easy to apply, and safe in that at no time did it produce irritation or allergic reactions, either on patient or attendant. It received general acceptance from the personnel because it obviated removal of sticky dried crustings of feces and ointments mixed, and it was aromatic. It did not soil diapers or bed linen.

Three cases of eczema were treated with Bactine. The response

in one of these was fair; two were poor. In none of the three cases, however, was there exacerbation of the eczema. Eight cases of rash and excoriation of the neck: in four the response was good, in one fair, and in three poor. Two cases of furunculosis: one response good, one poor. One case of excoriated axilla: poor result. Three cases of generalized miliaria: response in all cases was good.

#### CONCLUSION

It may be concluded that Bactine is a safe, satisfactory and agreeable method of handling mild and severe diaper rashes and excoriations. It also seems to be useful for minor skin irritations, in particular miliaria.

145 East 21st Street.

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TERRAMYCIN IN INFECTION IN CHILDREN. (British Medical Journal, London, 1: 419, Feb. 1952.) This report is based on the use of terramycin in 66 children: 35 with pneumonia, 10 with upper respiratory tract infections, 6 with tonsillitis, 3 with pyuria, and 12 with purulent conjunctivitis. Terramycin was available in capsules as the crystalline hydrochloride salt, and as a yellow crystalline powder that dissolves easily in a specially prepared cherry-mint-flavored liquid to make an elixir. A solution containing 25 mg. of terramycin as the crystalline hydrochloride dissolved in 5 cc. of distilled water with 62.5 mg. of sodium chloride and 25 mg. of sodium borate, was available for ophthalmic use. The elixir was given every six hours by mouth in doses of 50 mg. per pound (450 gm.) of body weight per day for seven days to each of 54 patients. The nurses preferred it to other antibiotics, because it was taken so readily by infants and children. Thirty-four of 35 patients with pneumonia responded rapidly, in most cases within 24 hours; one patient with a Friedländer's bacillus pneumonia died. Ten patients with upper respiratory tract infections, six with tonsillitis, and three with pyuria also showed a rapid and dramatic response. Eleven of 12 infants with purulent conjunctivitis responded rapidly. There were no toxic reactions, and it is stressed that terramycin, because of its wide spectrum of antibacterial activity and its easy administration, is particularly valuable in pediatric practice.—*Journal A.M.A.*



## CHLORAMPHENICOL IN MEASLES

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The treatment of measles (rubeola) up to now has been very discouraging. If the child has had gamma globulin early enough in the incubation period, he is lucky. If not, cough medicine will make him a little more comfortable, antipyretics may reduce the height of the fever temporarily, and sulfa drugs or penicillin will help prevent complications.

In the average case, however, the little patient will "cough his head off," and run a high fever from 4-8 days in spite of treatment. Many parents, therefore, will not even ask the doctor to see the child during an epidemic, preferring to let nature take its course. Measles, as distinguished from "3-day measles," and other so-called measles, is a serious disease in itself and may frequently have disabling or even fatal complications.<sup>1</sup>

Since the causative agent is a virus, and since the newer antibiotics have made a dent in this field, it was logical to consider chloramphenicol in the treatment of this childhood disease. The aim was to cure if possible, but at least to alleviate. This study was conducted during the 1952 epidemic before the shadow was cast over the drug because of a possible relation to aplastic anemia. This is a serious allegation and difficult to prove, but it has discouraged further widespread use. So far as we know, chloramphenicol is otherwise devoid of serious toxic reactions.

In the recent measles epidemic, the first case improved so rapidly under this treatment, by coincidence or otherwise, that it was decided to use it routinely and to check the results. The patients would have among the best of prophylactic medication, and could be benefited in the actual treatment. In this series, the drug was used in the form of Chloromycetin Palmitate.\* It is thus well tolerated and very palatable. The dosage recommended is from 50-100 mg. per kg. per day in 4-6 divided doses; we used about 50 mg. per kg. per day.

The children under consideration were all private patients of middle-class circumstances. In this group the follow-up is difficult, since many will not return for a final check-up, when the child looks well. There were 44 patients who received chloramphenicol.

\*Chloromycetin Palmitate, Parke, Davis and Company.

1. Mitchell-Nelson: Textbook of Pediatrics, 595, 597, 1970.

and of these, 30 returned for an evaluation of treatment. All were started in the Koplik's spots stage, that being the earliest reliable sign of measles, and usually the third day of illness; the drug was continued for 48 hours after the temperature returned to normal.

The Table 1 gives a graphic representation of the results. The estimate was based mainly on the duration of fever after the medicine was started, but also on symptomatic improvement:

TABLE 1. *Duration of Fever Under Treatment Related to Number of Patients.*

	1 day	2 days	3 days or longer
Male .....	5	6	5
Female .....	6	4	4
Totals .....	11	10	9
Percentage of total.....	37%	33%	30%

#### COMMENT

In this series there were no complications after chloramphenicol was started, and all were symptomatically improved within 24 hours, and an additional 30 per cent within 48 hours, irrespective of the period of measles. If the fever lasted more than 48 hours, the case was considered unimproved. An average expectation for normal temperature would be 48-72 hours after the rash begins to appear<sup>1</sup>, along with a certain percentage of complications.

It is quite possible that 75-100 mg. per kg. per day would have given even better results, and it is a point to remember in the next epidemic. One of the children in the series had cervical adenitis before the Koplik's spots, and before starting treatment, and another had bilateral otitis media, under the same circumstances, while a third had chickenpox as a concomitant condition. They all cleared up rapidly under the chloramphenicol.

#### SUMMARY AND CONCLUSIONS

1. Chloramphenicol, in the form of Chloromycetin Palmitate was given to 44 children with measles (rubeola), ranging in age from 1-8 years; the amount was 50 mg. per kg. per day in 4-6 divided doses. Thirty of these children returned for check-up and evaluation of treatment.

2. In 11 children (37 per cent), the temperature dropped to normal within 24 hours of starting the medication; in 10 more (33 per cent), the temperature returned to normal within 48 hours, making a total of 67 per cent. In the last group, 9 patients (30 per cent), the fever lingered for 3 days or more under treatment.

3. There were no toxic symptoms from the drug itself, and no complications of measles developing after the drug was started.

4. This report suggests that chloramphenicol is of great value in the treatment of measles (rubeola). In view of recent developments, blood counts would be indicated for any extended treatment, until this drug is exonerated.

19363 *James Couzens Highway.*

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FAMILIAL ERYTHEMA NODOSUM. (British Medical Journal, London, 1: 529, March 8, 1952). Fry defines erythema nodosum as a clinical entity consisting of a characteristic skin eruption, usually accompanied by a general constitutional disturbance. Although the etiology is not fully explained as yet, the general consensus is that it is a nonspecific reaction of a sensitive subject to various allergens. It is probable that erythema nodosum is associated oftenest with the primary tuberculous complex, but acute rheumatism, streptococcal infection, sarcoidosis, coccidioidomycosis, sulfonamide, hypersensitivity and a number of other conditions such as septicemia have also been observed with erythema nodosum. Fry describes a family with three children, aged 7, 5 and 3 years; the mother and the two older children had erythema nodosum lesions some weeks after bilateral open tuberculosis was diagnosed in the father. It seems certain that in the two children the development of a positive tuberculin skin reaction accompanying a primary tuberculous infection was associated with an eruption of erythema nodosum. This is also likely in the mother, but cannot be proved because there was no previous skin test. The author cites previous reports describing similar series of cases, and says that it seems likely that most of these multiple cases of erythema nodosum have been associated with a primary tuberculous infection.—*Journal A.M.A.*

## MATERNAL PSYCHOLOGY

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Some discussion of the basic female psychology and how it differs from the normal male psychology is necessary before it is possible to understand the more peculiar phases of maternal psychology.

Shortly after their birth a noticeable difference in the male and female psychology is apparent. The normal girl shows an early interest in dolls and clothes. She will mother her pets or younger brothers and sisters and express the hope of having children of her own in the future. While the boy may play as an infant with dolls, he soon shows more interest in mechanical toys and is apt to be more boisterous and destructive by nature.

As the girl nears maturity she develops manifestations of a quieter nature and is shyer, more sensitive and emotional. Most girls show a change in disposition at some point during the menstrual cycle. Those girls who have a regular 28-day-cycle will usually notice a definite relationship of a personality change corresponding to the phase of the moon. They will also notice that this phase is repeated on the same day of the week. When this phase occurs on weekends or holidays, they very often are too irritable to enjoy themselves to the utmost.

Once a girl has reached maturity she shows no decided psychological change, even after she is married, until she has become pregnant. Then she is an entirely different person. After her first child is born she is no longer a girl; she is now a mature woman who must always keep the protection and welfare of her off-spring uppermost in her mind. She now has her "*real live doll*." She continues to have interest in pretty clothes, not only for herself, but also for her child.

In the meantime what has happened to the boy? He has grown, finished his education, has a job, has married and fathered a child. He has not experienced pregnancy nor has he given birth to an off-spring. He remains psychologically the same except for a realization of more responsibility. His wife can't understand why he is interested primarily in business, sports, hunting, fishing, gambling and stag parties. He can't understand why his wife is inter-

ested in her new home furnishings, new clothes, a silly hat or a pair of frail high heeled shoes with holes in the toes.

From birth the male and female psychology are so different that for one to understand the other is as impossible as Kipling's verse, "East is East and West is West and ne'er the twain shall meet".

A previous paper (ARCHIVES OF PEDIATRICS, March 1943) gave the maternal psychology during the postnatal period. We recognize a definite change in all mother animals which is partially a defense mechanism to protect the offspring. In the human mother four very obvious personality changes are evident for a period of about three months following the birth of each child. The mother is noticeably more irritable and sensitive, particularly to any criticism regarding her care of the new baby. She is also bothered by a temporary amnesia for recent events. She can't remember telephone numbers long enough to dial them or she may leave something in another room and be unable to find it. The highly emotional mother gets periods of weeping without provocation. She also has undue apprehension about the new baby as well as any other older children.

When an American Indian squaw gave birth to a papoose she went to live for three months in her parents' tepee while the old buck father left for a three months hunting expedition after which time they returned to live together in their own tepee. Smart people Indians!

The pediatrician should recognize another definite female psychology which is not present in the male. This is a metaphysical sixth sense between a mother and her offspring. I am sure we have all been called to see an ill child, for whom the mother has assumed the responsibility to prescribe her own "remedies" for several days in order to save a doctor's fee. When she finally has shared her responsibility with the pediatrician her mental relief reflects in her child's condition, so much so that when the doctor arrives the child is playing or sound asleep for the first time in days. How many times have you arrived to see an ill child, and have the parents say that just a short time ago the child was much worse than it is now?

This metaphysical transmission of psychological stress is entirely a female trait. The mother can transmit her mental distress to either a son or a daughter until they reach maturity. After that

time they no longer are receptive but the daughter will affect her own offspring when she has children while the son will as a father be unable to do so.

The pediatrician must make every endeavor to give the mother peace of mind. The old saying goes that a father wearing mother's nightgown can't fool the baby when he is hungry. A mother who is mentally unhappy will not have a happy breast fed baby. Carnation milk has as a slogan "milk from contented cows". How much more important is contentment in a mother trying to nurse her child? I am sure that we all realize that an unhappy, crying, so-called "colicky" baby makes the mother more nervous and unhappy, therefore setting up a vicious circle. If there is any one factor in the presence of an adequate milk supply to satisfy the nursing child, it is an adequate supply of sugar in the diet of the mother, especially in between meals, thus keeping the blood sugar more evenly high which in turn insures a high content of sugar in the breast milk. The only food most apt to cause loose colicky stools in the mother's diet is grapes or anything from them, such as raisins, wine or cocktails. A small amount of alcoholic beverage, such as beer, ale or whisky, conserves blood sugar for the infant while the mother consumes the alcohol.

One other consideration to insure a happy infant is to find in which position the child prefers to sleep. Some infants will sleep soundly in any position; others prefer to be wrapped snugly in a blanket. Most infants try to get into the same position in which they spent nine months inside the uterus. Those who have no preference were probably floaters, rolling front and side and back. Those who are more contented on their backs were in an occiput posterior, while those who prefer to sleep on their faces were in an intrauterine occiput anterior position.

Just as mothers have this metaphysical power to influence their child mentally, they also seem to have a metaphysical intuition as to the seriousness of the illness. No matter how easily alarmed a mother normally is known by the pediatrician to be for minor illnesses, the doctor must always be alert for the extremely over-anxious mother and use extra effort to avoid overlooking a more serious condition than the obvious physical findings would indicate. As an illustration, many years ago I was called early one morning to see a new patient. She was about four years of age,



lying quietly on a davenport before the fireplace in no apparent pain. Her temperature was 101° F. orally; physical examination was negative. No positive neurological evidence could be elicited. Having gotten out of a nice warm bed to see a strange child not seriously ill, I told the mother that I didn't think the child had much wrong with her; whereupon the mother informed me that she knew her own child well enough to realize when she was seriously ill. I had been unable to elicit any nuchal rigidity but when I asked the child to sit up she had a tendency to move with a fixed neck. I told the mother that I was putting the child into the hospital for further tests. A spinal tap revealed 100 to 200 cells; no clouding but positive smear for meningococci. This happened long before antibiotic therapy became available but with intrathecal meningococcic antiserum she made an uneventful recovery and was sent home after three days of treatment. I am sure that this child would have gone on for sometime before a stiff neck became evident had it not been for the mother's intuition and apprehension concerning the seriousness of her child's illness.

Another more recent case of a newborn that cried in pain such as a so-called baby with "colic". She had had several changes of formula, x-ray for possible thymus and hospital care for observation before I saw her. The home conditions were not good as the mother was having some marital trouble and was living with her parents with her other child. This mother kept insisting that something was seriously wrong with her infant. Many different milk mixtures were tried along with antispasmodics and sedatives. At times she was very happy, acting like a perfectly normal infant. The mother insisted that the child be taken to the hospital. Upon arrival nothing could be found abnormal and the history revealed no definite type of "spell" to account for the mother's anxiety. The local doctor told the mother she was unnecessarily upset which she resented and stated that she was not a hysterical mother. Later the same morning the child had repeated attacks of "spells" during which time she seemed unable to breathe and was returned to the hospital. She was at this time four months old. Her second morning in the hospital she had a definite generalized convulsion which developed cerebrally-caudally, first the eyes, cheeks, arms, intercostals, then lower extremities. The clonic spasms of the intercostals were so severe that the infant could not get air into her

lungs and she was given oxygen. The attack lasted approximately four minutes and subsided in reverse to onset.

An airencephalogram showed extensive porencephaly of the right with some on the left. The mother could always foresee the possibility of recurring attacks 24 hours beforehand and would ask that her child be hospitalized. She called and requested that the child be hospitalized the day before its final attack. This mother had intuition concerning her baby from early infancy.

In summary: The female psychology is so different from the male that no man is able to comprehend it. The obvious differences are: 1. Postnatal maternal sensitivity. 2. The metaphysical maternal mental attitude, which is reflected in her preadolescent children. 3. Maternal premonition of serious illness in her children.

15 East Arrellaga Street.

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AUREOMYCIN AND CHLORAMPHENICOL TREATMENT OF HERPES ZOSTER. (Ugeskrift for Laeger, Copenhagen, 113: 1537, Nov. 15, 1951). In a given period Schaffer and Svendsen treated every other patient who had herpes zoster with aureomycin (500 mg. four times daily for four days) or chloramphenicol (from 2 to 4 gm. daily for from three to seven days). A total of 24 patients received antibiotic, and 22 control patients were given lactose tablets. No difference was noticeable between the treated group and the control group with regard to the duration of the skin affection or neuralgias.—*Journal A.M.A.*

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ENURESIS. (Medical Journal of Australia, Sydney, 1: 357, March 15, 1952). The incidence of enuresis is considerably higher among children who have had early and rigid toilet training than among those allowed to achieve control naturally (34 of 38 as compared with 2 of 35). Severity and coercion may succeed in establishing a habit of continence, but subsequent anxiety and frustration may cause regression. Restoration or creation of a favorable psychological environment free from anxiety and with opportunities for normal development may reverse the process and reestablish control. Enuresis was noted in only two of 36 children who were subjected to severe frustration but who had not had coercive toilet training. Frustration alone, therefore, does not produce enuresis; it merely initiates it.—*Journal A.M.A.*

# Archives of Pediatrics

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